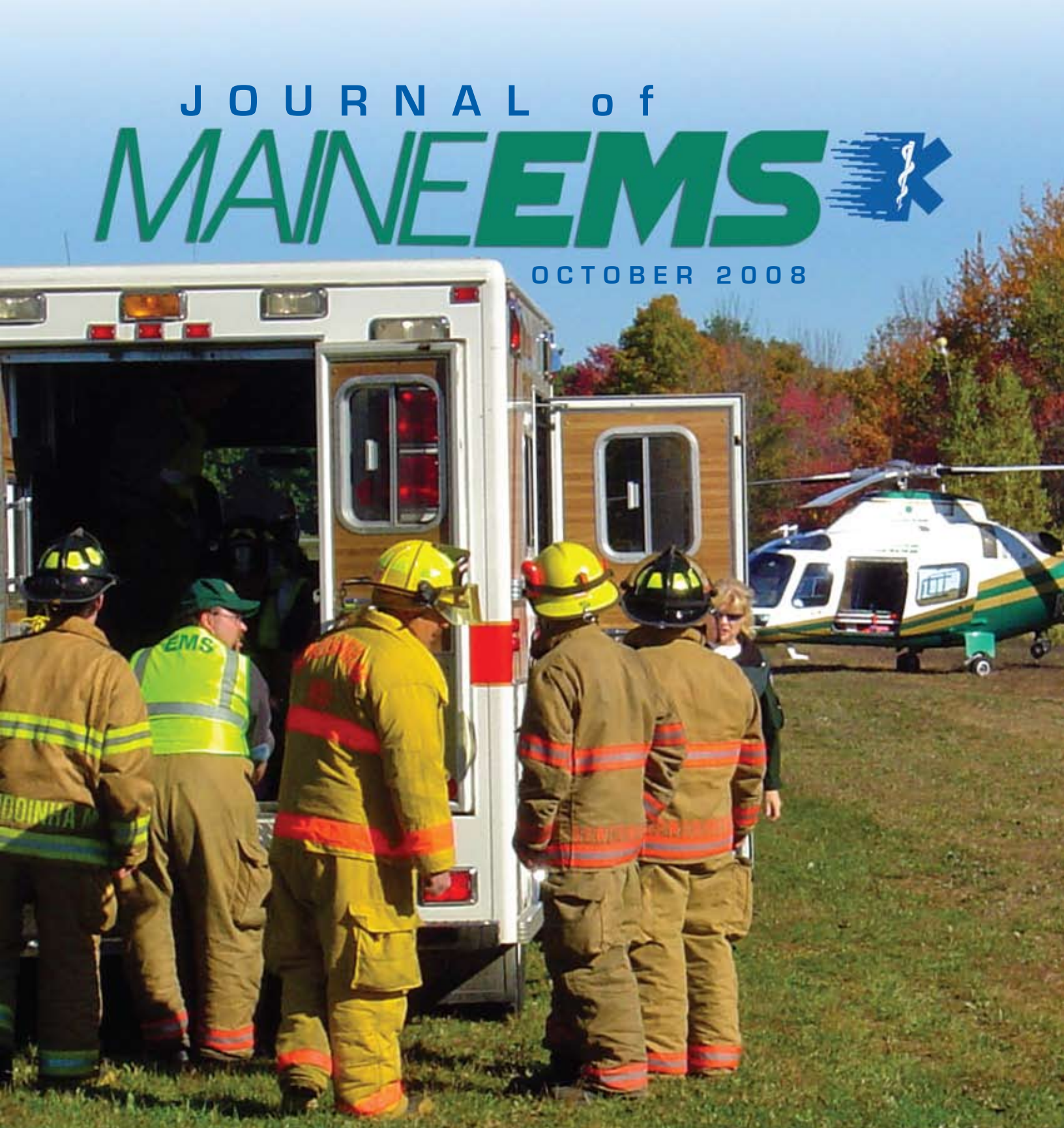
JOURNAL of MAINE EMS

OCTOBER 2008



INSIDE:

BY JAY BRADSHAW, EMT-P
DIRECTOR MAINE EMS

Respect....Responsibility...Professionalism

No matter how we get our news (newspaper, radio, TV, or the Internet), the stories are everywhere about how someone in the spotlight (like those running for elected office) has done something that makes us scratch our heads and ask, "What were they thinking?"

A person with many years of public service is accused of using their office to get personal benefits from businesses with whom they provide generous contracts; a church secretary is accused of taking cash from the offering; a high school administrative assistant pleads guilty to stealing over $26,000 from student accounts; or a municipal official uses a municipal vehicle to carry food and drink for a personal party.

It is troubling to say the least, and then causes us to look more skeptically at other elected officials, church secretaries, administrative assistants and municipal officials. Including folks who are honest, ethical, intelligent people doing honest hard work.

So what does that have to do with us? Everything.

The overwhelming majority of people in EMS fall into the latter category of honest, ethical, intelligent, and credible.

Given this fact, we wonder what is keeping our profession from being recognized as such and given the respect worthy of people who respond 24/7/365 at a moment's notice to all kinds of emergencies?

I would submit that one reason may be because there are those in EMS that don't take it as seriously. Folks who think that because once upon a time they took a course, that's good enough.

To be crystal clear, the latter group are measured in handfuls, while the first group are measured in thousands – but just as one corrupt politician causes others to be questioned and scorned, so too is it with EMS providers.

So what can we do about this?

We can begin by taking seriously our responsibility to keep our education, or certifications, and our licenses up to date.

Some may question whether this is really all that important, so let's ask ourselves a few questions.

How would you feel if you knew that a bus driver was unlicensed? How about a doctor, a nurse…or an airline pilot?

Licensing is a big deal, and rightfully so. Having a valid EMS, EMD, I/C license means that you are up to date with your training and education

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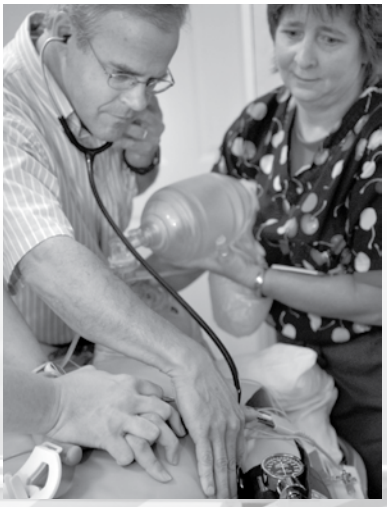
Hands-On Training Opportunity

The RV-based Human Patient Simulator (HPS) lab is available to provide one-of-a-kind onsite training to regional EMS services. The HPS, purchased with funds from the 2003 state transportation bond and owned by Maine EMS, is a mobile training lab designed to provide advanced emergency medical education to providers at all levels of care. The program started in 2006, visiting all the hospitals in Maine and offering 90-minute sessions of team-based training to hospital and EMS providers. The program was very successful in most areas, and now that awareness has been raised, the HPS is ready to expand its services and offer this customized training directly to fire and ambulance services.

LifeFlight of Maine crew members facilitate the training and have created an array of pre-programmed patient scenarios that can be used. However, if services have a specific training need, the team can also develop patient scenarios specific to that need.

For more information or to request a visit from the HPS, contact The LifeFlight Foundation at 207-785-2288 or visit www.lifeflightmaine.org.



Directions

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and that you have legal permission to operate within your respective scope of practice.

Things seem to happen in waves, and it seems that one of those waves over the past year has been people who let their license expire and continued to practice patient care, or continued to teach a class. And the reasons we hear have been both predictable, and troubling.

"My application got lost in the mail." Weren't you wondering why you hadn't received a license after 3 months?

"I thought someone else sent it in." Was it their license, or yours?

"I couldn't find a ½ hour of category 2." Really? Over a 3 year period?

"I forgot." Still unacceptable, but at least it's an honest response.

Keep in touch

EMS is a constantly changing field – across the country and throughout our state. As you read through these Journals, you will learn about many things that are happening all around us. Some of which will affect our practice and patient care in the coming years.

And it is our collective responsibility to be sure we know what's going on.

This means taking the responsibility to make an effort to stay informed. Publications like this Journal, JEMS, and our web site are all great places to start.

If you want to take part or know more about Maine EMS activities, all of our meeting notices and materials are sent out via e-mail. If you would like to be on any of these lists, just send us your e-mail address - and with very few exceptions, all of our meetings are open to the public.

We'll look forward to hearing from you.

See you in a few months.

The Licensing Corner

Dawn Kinney, EMT-P
Maine EMS Licensing Agent

While going through some of the older volumes of the Journal of Maine EMS, I came across an article written by Drexell White, EMT-P regarding unlicensed providers. This was a problem back in 1999 and is still a problem today. With his permission, and some modification, I am reprinting this article as it is such an important issue for providers and services.

Don't Let This Happen to You

During the past year, the Investigations Committee of the Maine EMS Board has seen an increasing number of investigations involving EMS providers who have either knowingly or unknowingly, allowed their licenses to expire and yet have continued to practice EMS patient care. Regrettably, these providers find themselves in the middle of a formal investigation and subject to substantial fines and/or license suspension. Additionally, the EMS service for which the non-licensed provider responds finds itself the subject of an investigation for allowing the non-licensed person to respond, and provide patient care, on behalf of the service.

In addition to the penalties imposed by the Maine EMS Board, individuals and services open themselves to potential civil liability for practice of patient care by persons not licensed. It's not too hard to picture the scenario of a litigious patient or family member, whose attorney checks into the circumstances of an EMS call only to find out that the person who responded and practiced patient care did not hold a current Maine EMS license. Also, for services, it is important to be aware that it is a violation of federal law to bill for services provided by unlicensed personnel. In such cases, the Centers for Medicare and Medicaid Services (CMS) can demand reimbursement for any such claims that have been paid, and levy substantial fines and penalties. (http://www.cms.hhs.gov/center/ambulance.asp).

So how can EMS providers and service chiefs make sure that this doesn't happen to them?

For Providers:

- Make sure that you remain aware of your EMS license expiration date—list it in your PDA (formerly known as a day planner), mark it on your wall calendar; post it on the 'fridge.
- Take heed of those reminder letters that Maine EMS sends to all licensees six months – and then again two months – before the license is due to expire. If you have a change of address, please notify us as we can not send reminder letters if we do not have a current address. These letters are designed as a friendly reminder to get your training in order and to submit your application well before your license expires. This will help you to avoid singing the "Hi Maine EMS, my license expires Sunday night and I'm scheduled to work on Monday morning and I need CEH's/refresher" blues.
- Don't assume. We've all learned what assuming does when it comes to field practice, so don't do the same with your license. Don't assume that just because you've completed your refresher/CEH program or renewed your National Registry certification, that you'll automatically be relicensed (you won't); don't assume that your well intentioned service chief won't accidentally misplace—or light his wood stove—with your licensing application package (always keep a copy for your records) that you gave him to mail (he might); and, don't assume that it's really not such a big deal if you practice EMS patient care without a license (it is!).

For Service Chiefs and Managers:

- Establish and follow a clear policy for tracking the license expiration dates of the EMS providers within your service. This includes everyone from the "old reliable" member of 20 years to the per diem provider who's helping cover shifts. Insure that you have copies of each provider's Maine EMS license and that you routinely check the list of license expirations. This avoids having a person whose license has expired respond with your service, and it gives you the opportunity to make contact with the provider to arrange for any necessary relicensing requirements.
- Don't assume (sound familiar). Don't assume that just because you've sent in a license renewal for one of your members that it won't get lost in the mail or delayed (it happens). And don't assume that just because a member of your service states they've relicensed, that this is in fact, true (the provider could be assuming). With a simple e-mail or phone call to the Maine EMS office, you can check on the status of a provider's license; whether an application has been received for processing; or, if there is a delay in renewing a license (perhaps due to insufficient training). Maine EMS can also provide service chiefs with up-to-date service rosters. The Maine EMS web site can also be a source to get the status of the provider's license and obtain a CEH report. (http://www.maine.gov/dps/ems/ceh_report.html).

With a little vigilance, both providers and service chiefs can avoid the headaches that come with discovering that an EMS license has inadvertently expired. That's one headache we can all do without.

Maine Emergency Nurses Association

Tammy Lachance, RN, BSN, CEN
Central Maine Medical Center

Several new developments are in the works as this issue is going to press! By the time you are reading this article, the Maine ENA Annual Meeting & Education Day titled "Pediatric Emergencies" will have been held on September 12, 2008 at the Auburn Hilton Garden Inn, three new people will have been elected for the 2009-2010 term (Secretary, Treasurer & Board Member At-Large), and the recipients of the 2008 Maine ENA Annual Awards will have been determined. The results of all of these will be included in the next issue, but if you're curious and can't wait that long to find out, go to the Maine ENA web site at www.enamaine.org!

UP-COMING MAINE ENA BOARD MEETINGS

Are you interested in learning more about ENA? Join us at a Board Meeting! All Maine ENA members are welcome to attend. Contact any Board Member for more information. Upcoming meetings are scheduled for 9am to 12 noon on:

- October 3, 2008 at the Eggspectation Restaurant in South Portland
- December 12, 2008 at Darlene Glover's Home

ENA-SPONSORED COURSES

Emergency Nurses Pediatric Course "ENPC"

2008 & 2009 Course Dates – Courses offered at several locations in Maine, dates and locations will be posted soon. Check the Maine ENA web site at www.enamaine.org or contact Carmen Hetherington, RN, BSN, CEN, Pediatric Committee Chairperson, at 795-2874 or hetheric@cmhc.org for information.

NEW OFFERING!!! ENPC has traditionally been a 2-day course for all nurses who take it, both for new providers and for those re-verifying. ENA has listened to the requests from its members and has created a one-day "ENPC Re-Verification Course", which will be offered at CMMC on October 27, 2008. Contact Carmen Hetherington, RN, BSN, CEN, Pediatric Committee Chairperson, at 795-2874 or hetheric@cmhc.org to register, space is limited.

Trauma Nursing Core Course "TNCC"

2008 & 2009 Course Dates – Courses offered at several locations in Maine, dates and locations will be posted soon. Check the Maine ENA web site at www.enamaine.org or contact Geneva Sides, RN, BSN, Trauma Committee Chairperson, at sidesboss@hotmail.com

INJURY PREVENTION – "EN CARE"

EN CARE is the injury prevention institute of the Emergency Nurses Association. The goal is to reduce the number of preventable injuries in the young, the adult, and the mature adult communities through public education, professional training courses and legislative advocacy. More than 5,000 emergency nurses, pre-hospital providers and law enforcement officers have been trained to teach EN CARE injury prevention programs, such as:

- Child Passenger Safety
- Bicycle and Helmet Safety
- Gun Safety – "It's NO Accident"
- Alcohol Prevention Education – "Choices for Living"
- Healthy Aging Education – "Stand Strong for Life"

One eight-hour day is all it takes to be recognized as an ENA Injury Prevention Provider. Anyone can take the EN CARE training course and there is no testing. If you are interested in taking this course, please contact Sarah Scott, RN at sascott19@aol.com.

FREE GUN LOCKS

Did you know that free trigger locks are available through ENA for distribution at events such as community health fairs or hospital events? Any ENA member may apply for 72 free trigger locks per event through a partnership between ENCARE and Master Lock. Free gun safety brochures are also available. To apply for the trigger locks and brochures, go to http://www.ena.org/ipinstitute/institute/guns/masterlock.asp. The request form is at the bottom of the web page. Please take advantage of this free merchandise and help make your community a safer place!

MAINE ENA WEB SITE

The new and improved Maine ENA web-site at www.enamaine.org is up and running. It contains lots of information, including:

- Membership benefits
- Upcoming events
- "Maine Matters", the newsletter of Maine ENA
- CEN review questions
- Contact information for officers, board members and committee chairs
- And more! Check it out!!!

Have a fun and SAFE autumn season!
Please store firearms and ammunition in separate locked locations and wear a helmet when riding an ATV or snowmobile. Ride safely!

EMS Across the Pond

This article is an addendum to the "Across The Pond" article in the July issue of the Journal of Maine EMS. John Wright is the Rapid Response Vehicle Project Manager for the Northern Ireland Ambulance Service. This is his tale of an EMS educational exchange experience here in Maine.

The Brief Anecdotal Meander

My trip to Boston started in a sort of surreal way when I left my house on foot and dragged my 22Kg suitcase to the nearest train station. It was 07:30 Hours and the family remained completely unfazed and in bed - no sign of a lift to the station or airport and barely a raised sleepy eye lid of goodbye – well I suppose I am only the main bread-winner!

Arriving in plenty of time at Dublin airport I met up with my fellow travelers for the first time. Paddy Duffy and James O'Neill both work in Southern Ireland and had brought their wives and in James' case his young daughter also. It was at this stage that I realized the trip was actually meant to be work and not a drinking session. I recovered from the shock of this and very nearly missed the plane having nipped off for a glass of wine in a bar with no public address system. Fortunately I managed to apologize my way past the American Immigration Officer and was about the last passenger on board. My seat had been taken by a lady who thought it was better than hers, but considering my lateness I made no fuss.

We were met at Boston Airport by Rick Petrie and his family. As many of you must know Rick personally you hardly need me to mention what a gentleman he is and how welcoming he and his family are. Fabulous hosts.

Day one was a rest and recuperation day and that meant shopping. It quickly became obvious that my two colleagues and their families were on a mission to take full and complete advantage of the exchange rate and the comprehensively stocked shops. We managed to fit in a pleasant lunch and spend a few rain-soaked minutes in a local beachfront park (Wellington??) where the tale end of a hurricane was bashing itself out on the coast line. That evening Rick took us to a Japanese restaurant and I enjoyed probably one of the finest meals I have ever had.

Day two was a rest and recuperation day following day one. After doing some shopping (again and not the last either) we spent the afternoon in Boston sight seeing and having an authentic Italian evening meal which was again fantastic.

Day three - Monday - was the start of the working visit. We traveled to Lewiston to run with United Ambulance Service. It was a lovely sunny day and for me it was really exciting to think that I was returning to what I knew was my favorite 'place' – ambulance operations. Though rusty from being in an office too much and lacking in confidence from being so far from my comfort zone NIAS, I really enjoyed the day:

The first call was for a cyclist knocked off his bike. He had learning difficulties and social problems and was known to the crew (Daphne and Jim). No real challenge and the first confirmation that ambulance operations are recognizable across the world.

I was interested to see the paramedic clearing the cyclists neck and making sensible positioning and transport decisions – there is a perception internationally that North America is fascinated with spinal boards and full immobilization.

The second call was for an elderly CVA patient to be transferred from one health facility to another. It was very familiar to me though from many years ago. In our pursuit of response times we endeavor to keep such patients off our A&E fleet and we move them using the high dependency Patient Care service. Doughnuts and coffee followed which is another international perception of North America!

We popped across town to attend to a psychiatric patient under the influence, or recovering from the influence, of C2H5OH. The Police were in attendance also – totally familiar territory.

After a short break we attended a five car Road Traffic Collision and I made a few notes to myself about this call. To summarize the notes: Patient assessment awesome - thorough, competent and complete. Cannulaes on the run, good kit – well maintained. Aggressive pursuit of standards and protocols. Very impressive professional behaviour.

The next call was for a man suffering what was apparently a recent and rapidly evolving CVA. The crew recognized the priorities quickly and they were rightly proud to have dealt effectively, efficiently and appropriately with the man when they got him to the receiving hospital within 20 minutes. We had a chat about the likelihood that the system would deal with him sufficiently quickly to ensure that thrombolysis if appropriate would be delivered in a timely fashion – again a familiar area of debate.

Our final call was for a 90+ year old patient with SOB and a Do Not Resuscitate Order (DNR). The crew carried out a thorough assessment and was able to communicate with her quite effectively. Clearly the paramedic felt that a diuretic and a nebuliser was appropriate and obtained both her consent for that, and also medical approval via the radio. This call was very interesting for a number of reasons: The Fire Department got there first and worked in close liaison with the crew. Indeed a couple of the Fire Fighters were part-time United folk too. This was very unusual for me as here in NI we only work alongside the Fire Service at entrapment RTCs and other similar trauma incidents. The Fire Service would have no expertise or interest in an ordinary medical call. Also the effectiveness of the ambulance / hospital radio link and immediate medical advice / approval was impressive. Here we

work by protocol and rarely if ever contact medical oversight in real time. Finally I wonder if the crew needed her confirmed consent to treat her. Was the treatment resuscitation, and was consent not implied by the fact that, though the patient was distressed, she was not struggling or objecting to a mask or any other interventions? Surely the treatment was designed to ease her distress rather than resuscitate her? Please don't berate me if my understanding is flawed. The crew were marvelous anyway and cared for the lady as well as dealt with her.

One abiding thought from that day at United is that the crews filled in very thorough run reports (we call them Patient Report Forms) having undertaken extremely thorough ambulance management of each incident. I have a perception that the thorough forms were not only in support of clinical governance, but also to ensure accurate billing – a concept totally alien to us here in NI.

An issue we debated as the day progressed was the squad bench concept. This is of interest in terms of the on-going health and safety issue of how paramedics should operate in the back of a moving ambulance. Clearly it is far too dangerous to be standing and seemingly the squad bench is not much better as three point harnesses are not best suited to sideways forces. Here in NI we have installed rotating seats that can be faced forwards during the transport phase. If the patient requires intervention then really the driver should pull over to ensure everyone's safety. For patients on a stretcher we utilise a six point harness that should ensure they do not shoot forward in the event of a crash. Central European Normalisation (CEN) compliance demands that our vehicles are crash-tested to 10G in 6 directions (or something like that) and all the fixtures and fittings have to withstand that level of force also.

By the end of the day I had decided to try and head-hunt some United paramedics. I started to ponder what it would take to get them through the HPC registration procedure and then to work for NIAS where their skills would be a great asset. I knew our pay scales would impress and that traveling would be of interest to many – even if only for a short time.

Unfortunately I was sufficiently tired, and indeed slightly over-awed by the day, that when I met the Operations Manager for United, not only did I offer him a NIAS plaque but also a clip-on NIAS tie that I said was clip-on so that idiots could use it. I imagine he is still wondering why his hospitality was so poorly appreciated that the strange Northern Irish guy should call him an idiot. I apologize most profusely for this error in international diplomacy and hope that he can enjoy it as an after-dinner story in the future.

The following day we headed up to Samoset Resort in Rockport to attend the Mid-Coast Maine EMS Seminar (needless to say, we called into Freeport on the way to do some more shopping). Rick had booked me onto a series of classes that would fill the next 4 days and provide some quite fantastic CPD.

'No airway is difficult – just different'. Familiar? Well it will be for anyone lucky enough to have refreshed their intubation skills / airway management / surgical airways / needle decompressions etc. by attending one of Peter Goth's difficult airway lectures or labs. Brilliant presentations and practical demonstrations by the enthusiastic and dedicated Doctor has led me to stock my response car with 'bougies' and to view with happy contempt anyone trying the party-trick bougieless intubation. Ramping up my casualty to bring their ears to the same level as their sternal notch will be my first thought the next time someone is unlucky enough to collapse on me.

Here in NI, to refresh our skills we have to attend hospital theatres and battle with medical students, reluctant anesthetists and other similar hazards before getting a few live intubations and supervised cannulations if we are lucky.

Following the two days of airway manikins, and sheep at various stages of the continuum between life and the dinner table, I attended two full days of lectures or classes. Some were excellent, some were less so, but the main thing of note was the enthusiasm of all those involved. Capnography 101, Cardiogenic shock, and diagnosing shortness of breath on the first day, and Heart failure identification and treatment followed by Trauma Case studies provided the final days learning.

My last lecture was 'That thing got a stemi'? I wonder did the flight paramedic who delivered the lecture think he had brain surgeons in the room?? My goodness he knew his stuff. Brilliant guy who needed a six week course to get us to his level!

In terms of social life we enjoyed a few very pleasant meals and many humorous hours chatting and exchanging anecdotes as ambulance folk always do. Steve Diaz showed up and as he and Rick are often in Ireland it was like old friends re-united. As we say here in NI – 'great craic' meaning lots of fun.

Many thanks again to all those involved in our 2007 trip to Maine.

MEMSRR Update

By Ben Woodard

As of August 2008, 131 EMS services have entered over 170,000 run reports into the Maine EMS electronic run report system, www.memsrr.org. Most services are entering run reports using the web based State Bridge direct data entry (82,000). 15 services using various NEMSIS Gold compliant software (Healthware Solutions, Zoll*, and Ortivus) have imported almost 35% of the call volume (52,000). 78 services have taken advantage of available grants and are using the Field Bridge mobile software with Panasonic Toughbook computers (36,000). Over 30 services are currently in training and gearing up to the switch to electronic run reporting. (* Silver Compliant)

For the remaining services time is going by fast to meet the 01/01/2009 start date set by the Maine EMS Board. Here is the process to begin switching over to electronic run reporting;

1.) Contact me at 626-3860, or ben.woodard@maine.gov to set up a time to build a database specific for your service. This process takes about 30 minutes to enter towns in your service area, vehicles, and other agencies, prioritize hospital destinations, etc. You can also email or fax me (287-6251) your current roster to be updated. I will mail you 2 part run forms to use instead of the 4 part run reports.

2.) Begin training providers in the use of the State Bridge, or other NEMSIS Gold compliant software. All software systems will incorporate the NEMSIS dropdown lists for data elements such as Dispatch Reason, Cause of Injury, Primary Symptoms, Provider Impression, etc. It takes the average user 6 practice run reports to begin to learn these lists. An excellent teaching tool is to give providers practice run sheets to copy.

3.) Notify the Hospital(s) when you are planning to switchover. Many of the hospitals will add more resources such as computers, printers, wifi to support electronic run reporting. Most hospitals already have staff that has access to the electronic run reports.

Training will be available at the regional level in October, November and December. Services can also organize training with local MEMSRR instructors. The State Bridge and Field Bridge software vendor Image Trend is also available for "webinar" online training.

Contact me for more info. Thanks.

Lights and Sirens

Public Safety Chili and Salsa Cook- Off to Benefit the Maine EMS Memorial

Postponed Until May 2009

KVEMSC has decided that due to low interest this fall we will be postponing our Chili Salsa cook-off to EMS WEEK 2009.

MEMSRR Electronic Run Reporting
The Who, What, When, Where and Why

Who – MEMSRR (Maine EMS Run Report) electronic run report and database. MEMSRR consists of:

- A web-based application called State Bridge (http://memsrr.maine.gov) EMS providers can login 24 hours a day / 7 days a week to enter, review or edit an electronic run report. This application also serves as the database for all electronic run report options.
- A tablet PC based software called Field Bridge that will allow EMS providers to write their report at the scene. This option is faster and more efficient for providers.
- Image Trend is a major EMS software vendor who created the State Bridge and Field Bridge software. Image Trend has received Gold Compliance recognition from the NEMSIS Technical Assistance Center, www.nemsis.org.

What – is NEMSIS? NEMSIS (National EMS Information System) is a national effort to standardize the data collected by EMS agencies. NEMSIS will be the national repository to store data from every state in the nation.

- Import of electronic run reports from software that has met the NHTSA 2.2.1 dataset and NEMSIS compliance for a national standard of data elements that can be easily transferred using the XML standard.

When - As of January 1, 2006 http://memsrr.maine.gov began electronic run reporting. Services using MEMSRR are helping to develop a data collection system that will not only meet NEMSIS standards, but give more accurate and timely information to the Maine EMS system.

- New services may join MEMSRR at 12:00 am of the first day of every month. This ensures no duplication of run reports and data.

How to begin using MEMSRR:

- Coordinate this transition with the hospitals to which services transport (The printed report will look much different than the paper PCR)
- Coordinate with the regional EMS office for QA/I purposes
- Train personnel in use of MEMSRR
- Agree to submit 100% of the run reports via MEMSRR
- Obtain written approval from Maine EMS

Where – MEMSRR can be accessed from any computer that is connected to the Internet. It is recommended, but not essential, that computers have a high-speed Internet connection to take full advantage of the software. The computer must also have:

- Microsoft Internet Explorer 6.0 and above (7.0 recommended)
- Other browsers that support Mozilla 4.0 and above
- Macromedia Flash Player 7 or above (9.0 recommended)
- Adobe Acrobat Reader 7 or above

Specifications for laptops/ Tablet PCs using the Field Bridge Data application:

- Microsoft Windows 2000/ XP/ Tablet PC Edition 2005 compatible
- **XP Tablet PC Edition 2005 is recommended**
- Microsoft .NET Framework 1.1 or higher (software interface)
- 350 MB of Hard Disk space required
- 128 MB Random Access Memory (RAM)
- **512 MB is recommended**
- Microsoft MapPoint 2002 or greater (Optional, for mapping features only)

Why - Electronic Run Reporting is more cost effective and with training and experience, time saving. Patient information and data are being stored in an electronic format throughout the healthcare industry. MEMSRR is designed to:

- Share aggregate patient care data between services, regions and states
  - o Facilitate data comparisons
  - o Dynamic access of critical information from other agencies
- Improve training guidelines based upon data
- Facilitate preparedness with syndromic surveillance
- Improve resource allocation
- Promote resource efficient growth
- Gain statistical evidence for funding
- Expedite billing
- Better manage staffing
- Track vehicle information

From the I/C News editor…

Greetings all!

How well do we demonstrate for our students that they need to be constantly seeking opportunities to improve their performance? I call it "making the call perfect," but you might call it something else, although it would have the same effect. I think we all do it in our classrooms when we run scenarios and ask students to self-evaluate. But how well do we give the idea that this process shouldn't end as soon as our students get their state licenses? When I was practicing as an EMT and paramedic, I would "make the call perfect" on the way home from almost all of my runs, not to beat myself up for what I didn't do, but to learn something so the next times I ran into similar circumstances I would handle it better and better. Depending on who else was on the call, many times I could do that out loud with my crewmates.

I remember my very first code as a paramedic. It was also the first code my service had run on its own without mutual aid. As we were returning to quarters, I asked the two other squad members who were also on the call what we might do to improve things in the future. One thing that had already occurred to me was that we didn't have trauma shears in the IV box and that would have made life much easier, so I'd made a mental note to add shears to the box. I was sure that other people would have similar suggestions. I was stunned, however, when one of my crewmates responded with anger, telling me that we did the best we could, and why did I want to look for the negatives.

Could I have asked the question differently and in doing so elicited a different reaction? Perhaps. Or perhaps no matter how delicately I had phrased it, it would have been seen as me looking to find fault. It's all in perception. I saw the review as an opportunity to learn from this call to make the next call better, someone else saw it as a threat.

As so often happens in this column, I pose questions to which I don't have any answers, but I put the questions out there as food for thought. In this case, I wonder if some people are inclined, whether by their inborn characteristics or by their upbringing, to hear any questions about a call or about their group's performance as a threat of criticism toward them as individuals. I know we see folks in our classes all the time whom we have to handle with kid gloves, who have a defense for everything they do, who argue with every evaluation instead of seeing it as an opportunity for growth.

I also know we see folks who, on the other hand, actively seek feedback, who take it to heart, make changes accordingly, and who grow because of their openness.

I'd like to think that, with our patience and understanding, we, as instructors, can have an impact on both groups of people. Obviously, it will be easier to have an impact on those who seek feedback. But perhaps it will be most beneficial for those who become defensive, because if we can get beyond the barrier they put up, we can help them to see their own potential for growth.

Teaching Tips

There are a number of things an instructor can do to make even reviewing a test a learning experience for his or her students. Here are a couple of examples. When students get wrong answers on their tests, the instructor can have them go back to their book (the teacher might even cross-reference each question on the test to the text page) and find out what was wrong with their answer. One option is that that would be the end of the exercise, but another option would be to give the students an opportunity to write, possibly for additional points, a brief paragraph demonstrating an understanding of either what was wrong with their answers or what makes the correct answer more right.

And don't we always have students who challenge either our test questions or our answer options? Sometimes that's a signal that we should review the question and make sure that it really says what we were intending. Once we are sure that the problem wasn't in how we phrased the question or our answer options, we can again offer the students an opportunity to expand their understanding. The students can be told that if they can find, in writing and in an acceptable resource, material that backs up why they were right and the teacher is wrong, they can earn credit for the missed answer.

Both of these examples require the students to actively participate in looking at their texts (and sometimes at other resources), spend more time with the material, go through the process of formulating a paragraph, manipulate EMS terminology, and so on, all of which increase their exposure to the material and, possibly, their retention.

Mike's Training Moments

By Michael James Azevedo, Jr. EMT B; Chief, Carmel Fire & Rescue

Greetings fellow EMS providers in the great State of Maine. My day has been very eventful. A full day at work, children's baseball game, another after school event with my daughter, and I just realized we have an ambulance meeting tonight. I am noticing that more and more of the emergency medical personnel that I work with are as busy as I am. So the thought of going to another meeting and sitting there for two hours really does not excite me.

Let's take a look at the people we work with. Many like the excitement of EMS, the thrill, the challenge, the camaraderie, the trauma (I hate blood), and the light and sirens. Many of us cannot sit still for five minutes, let alone suffer through 8 hrs of lecture and clinical rotations. So how do you keep my interest when I come to training?

Training exercises need to be practical, realistic and interesting. Please remember that most of your people are not EMTs full time, have children and spouses at home, have full time jobs, church, scouts, baseball and many other activities that take up their time. Please remember that their time is very important and so it yours.

Good training starts with Good Objectives. What do you expect me to take away from this training session? Tell me up front what you expect me to leave the training session with. If you tell me up front, I can help you make sure I have met the requirements. Every training session should start out with the important points, generally in this order:

1.) Welcome and thanks for coming.
2.) The location of bathrooms and coffee pot.
3.) The locations of the smoking area (for those who can afford.)
4.) The objectives of tonight's class.

Only after these four points can we begin to have a successful training session.

As I come up with an idea for training, I need to have some goals in mind. Why am I doing this training session? What do I hope to accomplish? Who does this session benefit? What equipment can I use? Test? Maintain? How can I use this training session to benefit my patients?

As I attend my Protocol Update class, I have just learned that I will be able to use a Glucometer. So let's put to use what we have learned in this column. After a training session on the glucometer, what are some of the objectives I might leave with?

1.) Know when I can use the glucometer.
2.) Know the location of the glucometer.
3.) Know what pieces are needed to use the glucometer:
    a. Control Solution
    b. Strips
    c. Machine
    d. Case
    e. Owner's manual
4.) Know how to turn on the glucometer.
5.) Know how to get a blood sample.
    a. What to use for blood
    b. How to get the sample
6.) Know how to clean and disinfect the glucometer.
7.) Know how to record the fact I used the glucometer.
8.) Know how to request more Control Solution and Strips.
9.) Return the glucometer to its spot in the ambulance.

A practical station would be to obtain the glucometer and run a control on it. It is no longer safe to practice on each other, but by running the control, you will be able to show you can use the glucometer. This is what I am going to require of each of my EMTs prior to allowing them to use this in the field.

We tend to think about glucometers when we are thinking about diabetes. This would be a good time to have a solid review of the types of diabetic issues. And these are becoming more common emergencies for emergency medical personnel. Remember that if you use the glucometer as a basic EMT, you must make sure that ALS is responding.

Also by setting objectives, the people that already have a solid foundation on the task at hand can quickly meet the objectives and go home (or work with someone who is struggling). This allows more time for others to practice without distraction. You can also use this outline with new people that may join your service. They may already have the training, but you can make sure they can use your equipment.

Until next time, THANK YOU for the people you train and the lives that are saved as a result.

Systematic Program Evaluation For EMS Education Programs

By Daryl Boucher, NMCC Assessment Committee Chairperson

What is an educational program evaluation, and why do we have to do it?

With the recent decision by NREMT to register only those candidates who have graduated from nationally accredited programs, EMS program directors nationwide are working to assure that their programs meet the national accreditation criteria. The Commission on Accreditation of Allied Health Education Programs (CAAHEP) (2008) standard IV B 1-2 states that:

"Programs must periodically assess effectiveness in achieving goals and learning domains… Outcomes assessments include but are not limited to exit point completion, graduate satisfaction, employer satisfaction, job placement rates, national registration rates, etc."

According to CAAHEP, program evaluation should be a continuing and systematic process with internal and external validation in consultation with employers, faculty, preceptors, students and graduates. In short, the basis for developing a systematic program evaluation plan is to answer two simple questions:

- How do we know that the program is meeting its objectives?
- How do we know that the program is producing qualified personnel?

Historically, most academic programs and institutions have used external reviewers to validate the quality of a program. This external review provides assurances to constituents, whether they are students or patients, that the organization is meeting the very minimum of standards. In EMS education, this has not been the case. Program quality has been evaluated solely by those offering the program, or in many cases, has not been evaluated at all.

The purpose of any external review process is to assure compliance with established standards and to allow program leaders to continually improve. It allows students seeking a specific education to objectively compare the quality of programs they are considering. Additionally, having a systematic plan for evaluation is crucial in preparing for upcoming accreditation site visits and demonstrating to others the quality of a program, as compared to established benchmarks, thresholds, or national statistics.

Instructors in the classroom have used some of the components of program evaluation for many years. The most common of these is the student opinion survey. From these survey results, instructors have adjusted and adapted their courses in an effort to improve. It is common to hear faculty discussing pass rates on national exams, or to have instructors informally discussing recent program improvements or changes. Gather a group of state instructors together and before long the conversation turns to a comparison of admission requirements or attrition in programs, or the lack of preparation of students, etc. With changing requirements regarding accreditation, the goal now is to take those informal discussions and formalize them into a sound program evaluation plan.

Components of the plan

Before program leaders develop a program evaluation plan, it is important to identify key items about which they want to learn. The plan should answer:

- What do we want to know?
- What should we measure and how should we measure it?
- What are the thresholds/expected outcomes?
- What will we do to fix identified problems?

Typically, high risk, problem-prone, or commonly occurring issues have been assessed. For example, if ambulance directors complain that graduates of a program don't seem to be "road-ready," educators may come up with a plan to improve the readiness of future graduates. Or, if pass rates on national exams are lower for one instructor as compared to another, the program may choose to have those instructors collaborate to improve pass rates for that first instructor.

The first step should be to get together a committee consisting of people who know the program well and can help identify problems or concerns. Sometimes, because of a lack of available data, no problems have been identified; in those cases, the data collection can begin by having the committee look at some of the required components. At the very minimum, every plan should address the following items:

a. Exit point completion: This is frequently referred to as attrition or retention. How many students started the program? How many students finished the program? Typically, most programs

Please submit any materials you would like to have published in the next issue of the I/C News by November 1, for publication in the January edition of the Journal of Maine EMS. Submit material to: Jacky Vaniotis, 172 Haskell Road, North Yarmouth, ME 04097, or email JackyV@Vaniotis.com

allow for a 10% attrition rate. Higher attrition indicates a need to look at system processes such as availability of tutoring, admission requirements, etc.

b. Graduate satisfaction: Student opinion surveys remain an excellent way to evaluate the program. These should be program-based rather than instructor-based, however.

c. Employer satisfaction: Employers of graduates should be surveyed objectively to identify strengths and weakness of entry level employees.

d. Job placement rates: Programs need to assess whether their graduates are employed in their chosen field of study, or if they have chosen to continue their education.

e. National Registry/state licensing exam pass rates: Leaders should assess pass rates on licensure examinations. Most programs establish thresholds at about 90% first time pass rate. It is useful to compare these numbers to national and state databases.

Once the data is collected, then program leaders are obligated to develop a plan to address outcomes that don't meet thresholds. These remediation plans should be written and adhered to, and all program constituents should be aware of the plan.

In future articles, we will discuss how leaders can begin the data collection process and develop remediation plans. For additional information about the program evaluation process, visit the CAAHEP standards and guidelines. Many sample evaluation plans are available on the World Wide Web.

Regional News

SMEMS

Donnie Carroll reports that, after having served as an interim Education Coordinator for Region 1, Paul Salway has been selected as the region's permanent part-time Education Coordinator.

Paul is currently contacting all Region 1 I/Cs to conduct a survey of their teaching interests as well as to start an e-mail group. The e-mail group will be used to provide I/Cs with information about teaching opportunities, to help individual services meet their educational needs, to send out updates of importance to the region's I/Cs and to send out the minutes of the monthly regional Medical Control meetings.

Committee Briefs

Education Committee

Jan Brinkman, RN, EMT-P; MEMS Education & Training Coordinator

The Education Committee meets at 9:30 a.m. on the second Wednesday of each month. Please call the MEMS office to confirm the date and time of a meeting before coming. All are welcome! If you cannot attend a meeting, but would like to comment on our projects, please feel free to contact Dan Batsie, Education Committee Chair (dbatsie@emcc.edu) or myself (jan.brinkman@maine.gov).

Exam Committee

By Jacky Vaniotis, RN, NREMT-P, Chair, MEMS Exam Committee

The Exam Committee has taken a few months off for the summer, but before its hiatus, it reviewed its activities for the past year in order to provide its annual report to the Board. The following items were included in that report:

- The Exam Committee updated the EMT-Intermediate written exam, which is the only written exam still maintained by Maine EMS.
- The committee reviewed Maine's testing candidates' scores since the conversion by the National Registry from pencil-and-paper testing to computer-based testing. (Data from this are still preliminary for two reasons. One is that the sample size is still fairly small. The other is that the data include as "first attempts" those candidates who had not passed the written exam in the months immediately preceding the switchover, so some "first attempts" had already failed the exam twice.)
- The committee oversaw changes to the Integrated Practical Exam as recommended by the Committee and approved by the Board.

The Committee's remaining goals for 2008 are to review and update the Exam Administration Manual, to continue to review the IPE data, and to conduct an item analysis of the revised Intermediate written exam to ensure its continuing quality.

Please feel free to attend any meeting of the Exam Committee, which meets on the second Tuesday of each month at 9:30 a.m. If you are planning on attending, please contact the MEMS office to make sure a meeting has not been canceled or rescheduled.

Three for the Price of One

Greetings, Colleagues! I have three small pieces for you this issue: local, state, and national.

One in 700,000

In July, I had a one in 700,000 experience. No….I wish it was Megabucks, but I guess I'm not retiring soon.

I was at my kitchen sink scrubbing a cast iron griddle with salt to clean it. I had no water running, because cast iron isn't supposed to see water, I'm told. We had one of those summer thunder storms crackling all around us; actually fiercer than most and very close by. I had the griddle perched on the side of the sink in my left hand and was scrubbing with my right. I suddenly felt a warm tingle in my left arm, followed by a baseball bat blow between my scapulae and a house rattling BOOM!!

Brain cells finally coming back on-line, I replied

"I think I was hit by that lightning!"

I looked up to see if the ceiling had fallen in on my back, but all was normal. I numbly took a couple of steps into the hall and went down to the carpet, voluntarily or not I'm not sure. I had yelled when this happened, I guess, so wife, dog, and cat came running, asking, each in his/her own way ,"What happened?"

Brain cells finally coming back on-line, I replied "I think I was hit by that lightning!"

Dogs and cats would make good EMTs if they only had thumbs: each sniffed me thoroughly (primary survey), licked my face repeatedly (secondary survey) and then glued themselves to me on each side (basic life support).

I checked my pulse (80, regular, no extra beats), sniffed for burned flesh (none), assessed my mental status (as good as it gets), and other signs (shaky but okay) and, of course, dismissed the notion of seeking medical care almost instantly (hey, I'm a medic, right?).

Now we all know the basics of not getting hit by lightning when outside, but inside? I have treated a patient who was struck by lightning when he was sitting on a toilet (I shudder just thinking about THAT burn!), and unplug important electrical devices during electrical storms, but otherwise haven't given it much thought. So, just so you can be smarter than I (not hard to do generally speaking and particularly as this episode indicates) next storm, heed the following advice from http://www.lightningsafety.com/nlsi_lhm/lpts.html and http://www.lightningsafety.noaa.gov/indoors.htm respectively:

"Measuring lightning's distance is easy. Use the "Flash/Bang" (F/B) technique. For every count of five from the time of seeing the lightning stroke to hearing the associated thunder, lightning is one mile away. A F/B of 10 = 2 miles; a F/B of 20 = 4 miles…. Be conservative and suspend activities when you first hear thunder, if possible. Do not resume outdoor activities until 20 minutes has past from the last observable thunder or lightning."

"Summary of Lightning Safety Tips for Inside the Home

1. Avoid contact with corded phones.
2. Avoid contact with electrical equipment or cords. If you plan to unplug any electronic equipment, do so well before the storm arrives.
3. Avoid contact with plumbing. Do not wash your hands, do not take a shower, do not wash dishes, and do not do laundry.
4. Stay away from windows and doors, and stay off porches.
5. Do not lie on concrete floors and do not lean against concrete walls." (They may contain metal "rebars" used as support when they were poured).

The Maine EMS Memorial
It's the Right Thing for Everybody in EMS

Several years back, as I drove by the fire and police memorials in Augusta, I got thinking about the absence of an EMS memorial. We had established a plaque for on-duty deaths at Maine EMS and there were, fortunately, few of which we knew. But should that be a reason not to have one? As I thought more about it, the more I thought not only was that answer "no", but I thought of another reason for establishing an EMS memorial: simple recognition of an incredibly dependable and good system upon which the public depends, but which is largely invisible.

Police and fire stations are usually central to the communities they inhabit, and citizens are aware of them. Police on patrol are routinely present in our experience (sometimes more so than we'd like… not that I speed or anything). Fire departments have lots of big vehicles, often on display. These are reminders of important public safety service that we depend on.

EMS? We live in largely non-descript garages, or in the back of hospitals or fire houses. We rarely take the time to sound our own prai-

We frequently create comfort and calm out of chaos and fear.

Yet rarely are we thanked.

The NHTSA EMS office has come to fill a broader EMS leadership role than just curriculum development.

It has been the mover and shaker in recreating federal EMS leadership.

ses. We can save lives from time to time, but we often take bad situations and simply make them better. We frequently create comfort and calm out of chaos and fear. Yet rarely are we thanked. But we don't think much about that, and just go on with it because we're EMS and we know we are needed and that's good enough.

But that's not good enough. I believe that we need an EMS memorial in Maine to recognize not only those who have lost their lives during EMS service, but to recognize every EMS professional, volunteer and career, who does this incredibly difficult and important job. The people who rely on us see the occasional ambulance and see EMS staff on TV. They are aware of emergency room doctors and nurses and public safety dispatchers. But they have no idea how these people come together in an organized system of response and care that is the EMS they get when they call 9-1-1. An EMS memorial can begin to change that.

We started to establish such a memorial nearly five years ago. We got the approval of the legislature and a couple of commissions to use the land adjacent to the police and fire memorials, and received design approval. This took nearly three years. This year we announced the start of fund-raising, with hopes to break ground next year, perhaps during EMS week.

The Maine EMS Memorial will recognize the fallen EMSers, as it should, but it will uniquely recognize each of us: EMT, first responder, paramedic, doctor, emergency medical dispatcher, and nurse. It will do this through a unique visual design with an integrated auditory component. This latter piece will allow visitors to use cell phones to hear the "stories" of the fallen and also of the typical volunteer EMT, career paramedic, emergency physician, trauma surgeon, critical care or emergency nurse, or dispatcher (and others). Similarly, the Maine EMS system story can be told.

The Memorial project fundraising committee has sent out a request to EMS services, hospitals, and associations for each to donate $1,000. This would provide the $300,000 needed to build and maintain the Memorial. We know this is a lot for some services and difficult to do for others because of municipal bureaucracy. But whether it is extra bake sales, extra budgeting steps, or asking a bigger service or hospital for a little help, it is simply the right thing to do. Please help us get you and your contribution to Maine recognized.

Back in the Saddle....?

In 1973, the Federal EMS Systems Act gave birth to modern EMS as we know it today. It put radios in ambulances, defined the EMS system, helped train EMS providers, and generally furthered EMS development with a large shot of Federal funding. It also created an EMS program in what became the US Department of Health and Human Services (DHHS), which provided technical assistance, grant funding for system development, and general guidance until it was eliminated in 1983. This left little overall Federal leadership in EMS.

One long lasting exception was an EMS office in the National Highway Traffic Safety Administration (NHTSA) in the US Department of Transportation (DOT). It actually predated the DHHS EMS program and had begun in the late 1960's to establish curricula for training EMS personnel, a job that it maintains today.

The NHTSA EMS office has, over the past several years, come to fill a broader EMS system leadership role than just traffic safety issues and curriculum development. In the past two years, NHTSA has been the mover and shaker in recreating the Federal Interagency Committee on EMS (FICEMS) and the more recent National EMS Advisory Council (NEMSAC). The former is a group of Federal agencies with EMS responsibility and the latter is a committee, like the regional EMS councils or EMS Board in Maine, which has members representative of the EMS field. Tom Judge, executive director of LifeFlight of Maine, is one member.

Together, under the leadership of NHTSA's EMS office, NEMSAC and FICEMS are where the action is at for moving EMS ahead nationally. More on both can be found at:

http://www.nhtsa.dot.gov/people/injury/ems/EMSNewsletterWinter07/index.htm#1.

Kevin was the director of Maine EMS from 1986-1996, is a member of Winthrop Ambulance Service and currently works for the National Association of State EMS Officials as a program advisor. He also serves Maine EMS as a part-time trauma system manager.

Tradition and Honor

The importance of our logos

By Rob Simmons, EMT-C

Every day as we practice our skills in preparation for being "at the big one', we do not realize or have forgotten what we truly represent as we perform our duties. We all too often are unaware of the impression we give to the public just by our presence. The very symbols of Fire and EMS have a rich and significant history. Each logo that we display on our uniforms, emergency equipment, and even our stationary has a profound impact on our jobs and public perception.

Let's examine the two symbols we use the most in our profession, the Maltese Cross and the Star of Life. Both of these are easily recognizable throughout the civilized world to represent helping, life, and healing. They are associated with heroic deeds, compassion and understanding. Anyone wearing either of these logos is thought to be someone with who can be trusted with others lives and property. But how did they come to be connected with fire and EMS?

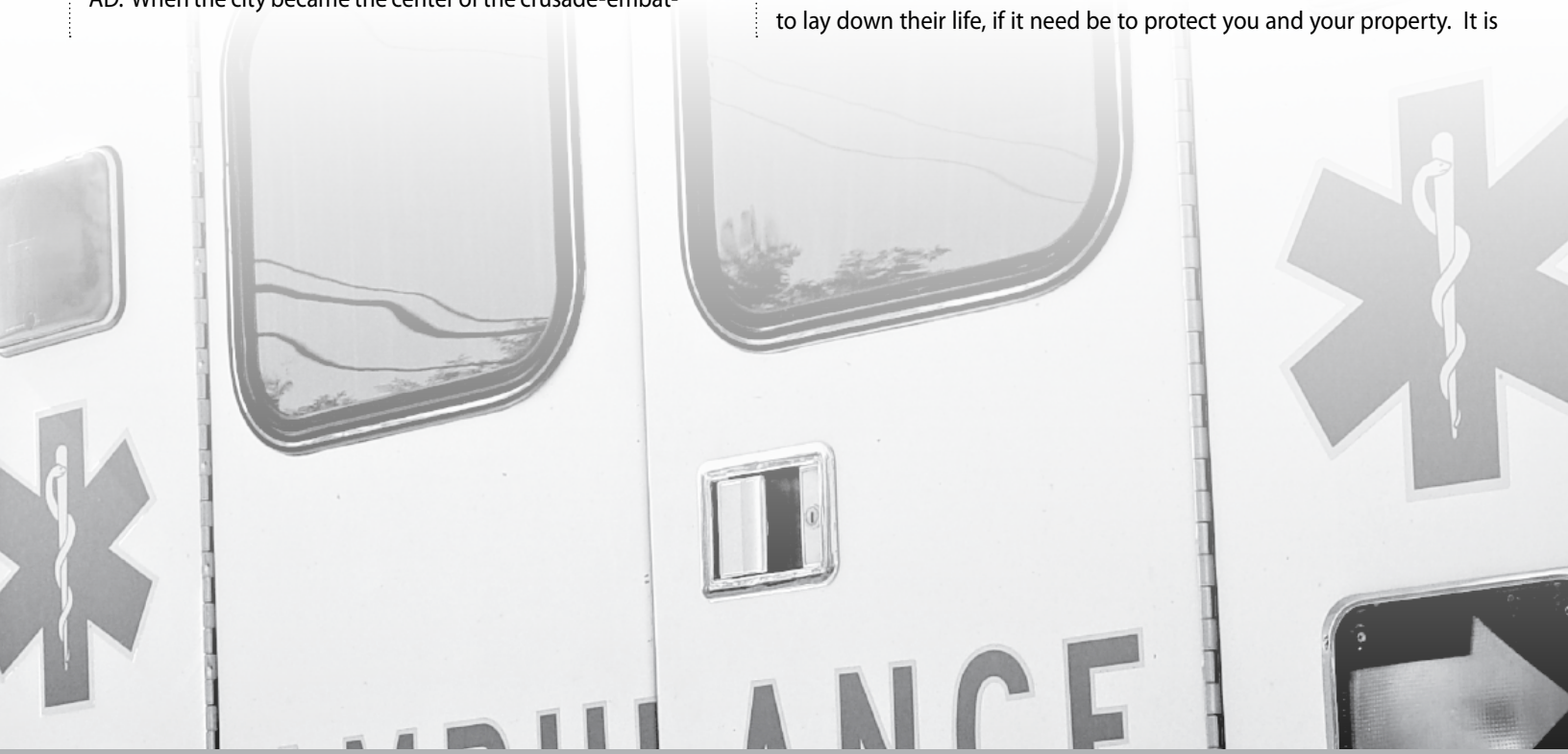
In order to understand these two signs, we need to look to our past. Some of the earliest firefighters known in history were a particular order of Knights during the Crusades. The Knights of St. John of Jerusalem were one of the oldest orders of warrior monks. They took vows of poverty, chastity and obedience. Also known as the Hospitallers, the monks maintained a hospital for pilgrims in Jerusalem around 600 AD. When the city became the center of the crusade-embattled lands, the brothers militarized their order, but continued to protect pilgrims and care for the sick and the poor.

Because of the extensive armor that covered their bodies and faces, Knights were unable to distinguish friend from foe in battle; thus the need for an identifiable emblem. The Knights chose the Crosse of Calvary, four converging spear heads that resembles a white or silver eight pointed cross on a dark background.

When the Knights fought the Saracens for the possession of the Holy Lands; they encountered a new weapon unknown to European warriors. It was a simple but effective device of war. As they advanced, the Knights were struck by glass vessels containing naphtha. When they became saturated with the highly flammable liquid, the Saracens hurled flaming torches into their midst. Hundreds of Knights were burned alive as they attempted to save their brothers in arms.

Each of the Knights who managed to save a brother from that horrible fate had their heroic efforts recognized by fellow Knights who awarded them a badge of honor, a cross similar to the one worn by firefighters today. This cross became the official badge of the Order in 1023 AD. After the fall of Jerusalem in 1187, the Knights moved their Order to the island of Malta where they lived for the next four centuries. This was where their emblem became known as the Maltese Cross.

The Maltese Cross is a symbol of protection, when seen by the average citizen. It means that the men and women wearing this cross are willing to lay down their life, if it need be to protect you and your property. It is



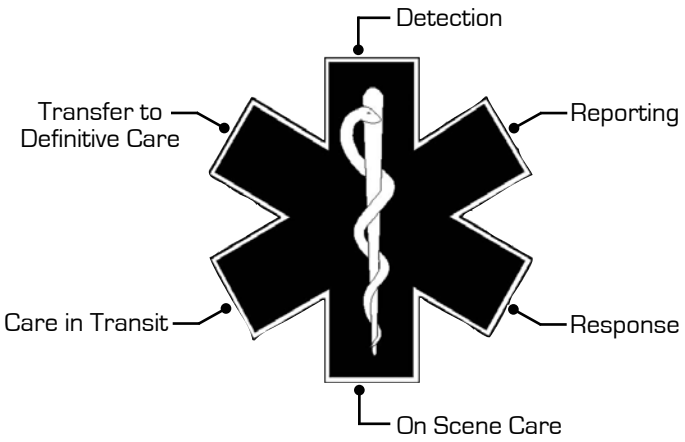
certainly a firefighter's badge of honor, denoting courage, training and the ability to work at death's door.

Now let's look at the symbol that represents Emergency Medical Services. The logo that was used before national standards for Emergency Medical Personnel or ambulances were established was an orange cross on a square background of reflective white to designate them as emergency units. In 1973 after the American National Red Cross complained that the orange cross too closely resembled their logo, the Red Cross on a white background, Leo R. Schwartz, Chief of the EMS Branch, National Highway Traffic Safety Administration (NHTSA) designed the Star of Life. The newly designed cross was adapted from the Medical Identification Symbol of the American Medical Association, and was patented on February 1, 1977. The logo was 'given' to the National Registry of Emergency Medical Technicians (NREMT) for use as the emergency medical technicians (EMT) logo after the patent expired in 1997.

The blue star is a symbol of the angels. The six branches of the star are symbols of the six main tasks executed by rescuers all through the emergency chain:

- Detection -The first rescuers on the scene observe the scene, understand the problem, identify the dangers to themselves and the patient(s), and take appropriate measures to ensure the safety on the scene (circulation, electricity, chemicals, radiations, etc.).
- Reporting -The first rescuers call for professional help.
- Response -The first rescuers provide first aid and immediate care to the extent of their capabilities.
- On scene care -The EMS personnel arrive and provide immediate care to the extent of their capabilities.

THE STAR OF LIFE



- Care in transit - They provide medical care during the transportation.
- Transfer to definitive care - The EMS personnel proceed to transfer the patient to a hospital for specialized care. Appropriate specialized care is provided at the hospital.

The snake and staff in the center of the symbol, portray the staff, Asclepius, who according to Greek mythology, was the son of Apollo (god of light, truth and prophecy). Supposedly Asclepius learned the art of healing from the centaur Cheron; but Zeus - king of the gods, was fearful that because of the Asclepius knowledge, all men might be rendered immortal. Rather than have this occur, Zeus slew Asclepius with a thunderbolt. Later, Asclepius was worshipped as a god and people slept in his temples, as it was rumored that he effected cures of prescribed remedies to the sick during their dreams. Eventually, Zeus restored Asclepius to life, making him a god.

Asclepius was usually shown in a standing position, dressed in a long cloak, holding a staff with a serpent coiled around it. The staff with the single serpent represents the time when Asclepius had a very difficult patient that he could not cure, so he consulted a snake for advice and the patient survived. The snake, an ancient Greek symbol denoting eternal life, had coiled around Asclepius' staff in order to be head to head with him as an equal when talking. The staff and coiled snake shows the meaning of human efforts to support and fight for life and protect it as long as possible.

To know where you are going, sometimes you have to slow up and look at where you came from. As you see, there is more to the logos you display than just another "neat" design. The symbols you wear each shift represents thousands of years of history. The general public puts their lives and property in your trust, without question, based solely on the hard work of generations before you. It is a history of actions performed by those who sacrificed their lives so that others may live. Never forget the impact of what you represent and always respect the symbols of our profession.

Rob Simmons is a U.S. Navy veteran and a 19-year firefighter/EMT-C for the city of South Portland, Maine. He is a training coordinator for both the South Portland Fire and Police department honor guards, and a graduate of the U.S. Navy Honor Guard and Drill Team and the National Honor Guard Academy. He teaches honor guard classes through SMEMS and other local venues.

The Star of Life is easily recognizable throughout the civilized world to represent helping, life, and healing. It is associated with heroic deeds, compassion and understanding.

Improving Patient Safety Through Collaboration

William H. Dunwoody, MBA, CQIA, CMQ/OE, EMTP

Ever since the Institute of Medicine [IOM] published their report, *To Err is Human: Building a Safer Health System, a report on the state of the U.S. healthcare,* and the subsequent report*, Crossing the Quality Chasm: A New Health System for the 21st Century*, the focus of healthcare system development professionals, public activists, and government regulators has been on a search for new methods to improve the safety of healthcare delivery. The initial IOM report suggested that as many as 98,000 individuals died each year as a result of the care they received (Kohn, Corrigan & Donaldson, 2000, p. 1). The second report identified strategies for improving the safety of healthcare delivery.

One proposed solution was addressed by the 109th U.S. Legislature with the enactment of Public Law 109-41, also known as the Patient Safety and Quality Improvement Act of 2005. According to Douglas Dotan, the past chairperson of the American Society for Quality Healthcare division and the president of CRG Medical, "this Act demonstrates for the first time the federal government's commitment to create a system for the purpose of collecting, codifying, aggregating and analyzing patient safety information." (Dotan, 2008, p. 5)

The Agency for Healthcare Research and Quality [AHRQ] is empowered by the Act to establish criteria for the creation of private organizations that act as portals for the collection of information related to patient safety incidents and the development of processes to prevent patient injury. These Patient Safety Organizations [PSO] collect and distribute information between a national knowledgebase focused on patient safety practices and the users of the system. To accomplish this goal, each organization is charged with the development of a data collection system built around common data elements defined by AHRQ. In a move to encourage participation by healthcare providers and systems, the Act also stipulates that the PSOs be "set up independently to remove any fear of discovery of peer deliberations, medical malpractice litigation, and disciplinary actions for the person communicating concerns." (Dotan, 2008, p. 5) Federal legal protections are provided as a component of the Act. These legal safeguards include protection from disclosure for patient safety work product, defined as:

…any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements—"(i) which—"(I) are assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety organization; or "(II) are developed by a patient safety organization for the conduct of patient safety activities; and which could result in improved patient safety, health care quality, or health care outcomes; or "(ii) which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. (Public Law 109-41, 2005, Part C§921(7))

The Maine Patient Safety Network offers opportunities for EMS agencies in Maine to be part of the movement to improve care, establish processes to protect patients from injury, and to reduce the risks associated with the delivery of healthcare.

Since the PSO is developed as an independent third party, the ability to maintain confidentiality for both patients and providers is improved. Confidentiality of work product and the identity of participants are protected through Federal legal protections. While the State of Maine has protections from disclosure built into its EMS quality management systems (Title 32§92-A), the Federal protections offered by the Act go far beyond this law and allow for the sharing of confidential work product on a national level so the greatest benefit to the Maine healthcare system can be realized.

Public Law 109-41 is primarily focused on the care provided by hospital systems and other healthcare networks; however, the law defines a healthcare provider as "an individual or entity licensed or otherwise authorized under State law to provide health care services." (Public Law 109-41, 2005, Part C§921(8)) In the State of Maine this definition includes providers of Emergency Medical Services and this inclusion in the provisions of the Act presents a great opportunity for the EMS systems in Maine to be a front runner in the participation of a statewide EMS system in a national network for reporting best practices, lessons learned, and seminal ideas related to improving the safety of patient care. At the time of the writing of this article, discussions are scheduled with a large hospital based EMS system in New Jersey and further informal discussions on the idea of a national network for EMS Patient Safety Organizations are planned during the 20th EMS Expo in Las Vegas scheduled for mid-October.

To fulfill the needs of the current community based healthcare systems in Maine and to provide a mechanism for these systems to participate in the voluntary patient safety reporting program established by the Act, the International Institute for Organizational Excellence, LLC has created the Maine Patient Safety Organization Network. The Network is "designed to provide a portal for each medical system, hospital, physicians group, long term care facility, or other allied health group to manage knowledge in order to provide and share mechanisms to protect patients and reduce risk."

(Maine Patient Safety Organization Network, 2008) The Network has entered into a relationship with CRG Medical (www.crgmedical.com) and the Community Medical Research Foundation for Patient Safety (www.comofcom.com) of Bellaire, Texas to offer database and system development and analysis services. Both of these organizations offer the benefit of decades of safety systems expertise from the medical and aerospace industries to enhance the capabilities of Maine Patient Safety Organization Network.

While the subject of the research being proposed by the Act is not consistent with the clinical research recommended for the EMS system of the future in the IOM document, Emergency Medical Services at the Crossroads (2007) the participation of EMS systems in the prevention of patient injury has the potential to have as much of a positive impact on the care provided throughout the continuum of care as the research proposed.

The Maine Patient Safety Network is in the position to offer opportunities for EMS agencies in Maine to participate in this important initiative; to be part of the movement to improve care, establish processes to protect patients from injury, and to reduce the risks associated with the delivery of healthcare. Do you or your agency have the willingness and capacity to be an innovative leader in the Maine EMS healthcare system, to become part of a larger vision of system improvement that can impact the delivery of healthcare on a national scale?

For more information or to find out how you or your agency can participate, contact the Maine Patient Safety Organization Network at info@pso-me.org.

Bill Dunwoody is a PhD student, a Scholar Practitioner with the International Institute for Organizational Excellence, LLC and the President and CEO of the Maine Patient Safety Organization Network. He is a nationally recognized speaker and author on the subjects of quality management, process improvement, and performance excellence.

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The State of Sepsis:

Thanks to the efforts of MMC ED attending Samir Haydar D.O., the treatment of sepsis in our ED is being pulled into the modern era of EGDT (Early Goal Directed Therapy). The focus is now on early diagnosis and aggressive treatment often with copious IV fluids, broad-spectrum antibiotics, CVP monitoring and blood products as indicated. We hope that as protocols championed by Dr. Emmanuel Rivers of Henry Ford Hospital in Detroit become widely accepted within the hospital that we will see an improvement in our morbidity and mortality figures.

Although this issue will arrive too late to promote it , a conference on Sepsis will have been held on September 19th at Maine Medical Center. It featured Dr. Rivers and a number of interested local experts discussing the goals for treatment of Sepsis in 2008 and the mechanics of accomplishing those goals in a busy Emergency Department. Of course this process starts in the prehospital field following the leads of ST elevation AMI's and Thrombolysis for Stroke. Dr. Mike Baumann and Dr. Haydar are developing a draft protocol for Lifeflight of Maine. Recognition of sepsis will hinge on a brief patient history suggestion the onset of a new infection. Vital signs indicating fever or hypothermia, rapid heart rate and rapid respiratory rate may point to the development of SIRS (Systemic Inflammatory Response Syndrome) a precursor for sepsis. Further patient evaluation would include a search for end organ dysfunction such as altered mental status, hypotension, evidence of hemorrhage, and/or respiratory distress. Once sepsis is suspected fluid resuscitation in the range of 40cc/kg or up to 10-14 liters may be required and unless there is a history congestive failure, EMS can initiate this treatment saving valuable time in the ED.

LLSA…Portland , December 3, 2008

Please stay tuned for the location of the annual LLSA review in an upcoming mailer. Drs. Baumann, Alexander, Peredy, and Sweeney will present the 20 most recent articles covered in the LLSA in their concise and rapid-fire manner. Students will be able to take the test on site at the end of the day. Bring your laptops!

Sugarloaf 2009

It's never too early to think about skiing in Maine and the camaraderie of the Sugarloaf conference and with Carl Germann MD of Maine Medical center ED at the helm this year the 27th annual March conference will be more exciting than ever. Resident Jeopardy will return with Maine Med and Baystate ready for a rematch. There is even a new web site that you can peruse to get more information on the conference and the various activities planned: http://www.mmc.org/sugarloafconference. Register early and get a seat up front.

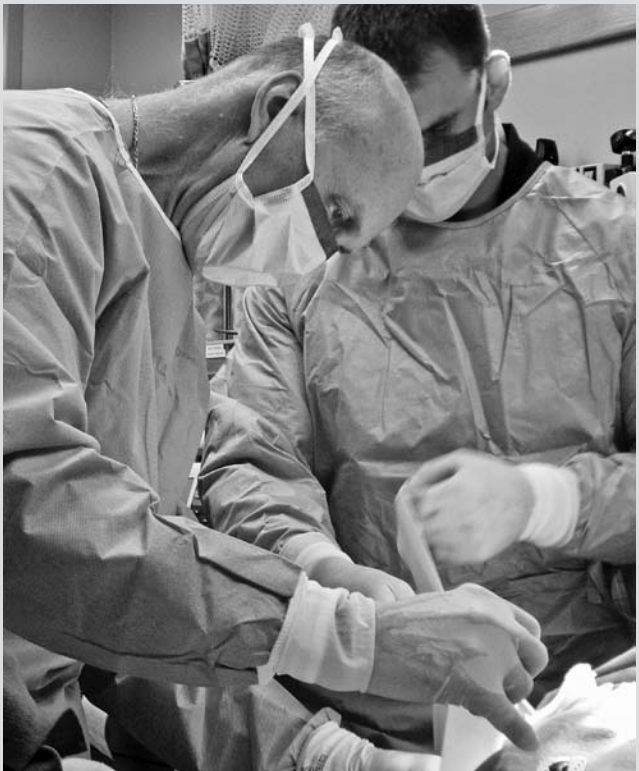
It's not easy being green

A day in the life of a newly graduated ED physician

Tripp Carter, MD
Portsmouth Regional Hospital

When asked to describe my first shift as an attending emergency physician, the first word that comes to mind is chaos. As many of you know, I completed my three years of residency training in June 2008 and was excited about a full time position at Portsmouth Regional Hospital. When one faces the prospect of practicing emergency medicine without the safety net of a more experienced physician watching your back, one naturally feels anxious and full of self-doubt. Will I know what I am doing? Am I going to miss something or do something stupid? Three years seems like an eternity when you are an intern, but when facing graduation, the time seemed to pass like the blink of an eye. Needless to say, I did not sleep very well before my first shift.

They started me with a Monday day shift on July the 14th. As many of you know, Mondays for whatever reason, tend to be high volume and high acuity days. My first day was no exception. Not but two hours into my shift and the department was full and yes, I was completely overwhelmed. I had many interesting experiences that day, but one patient in particular will forever be etched in my memory. His chief complaint was back pain that had started suddenly while he was at work at his desk earlier that morning. That seemed innocent enough given the amount of back pain we see in the emergency department. Except, this guy looked terrible nor did he have any prior history of back trouble. What struck me immediately was how diaphoretic he was. You cannot fake diaphoresis and this guy was drenched. He relayed having worked in the yard over the weekend and thinks he "pulled a muscle." But he followed that up with "he who diagnoses himself, has a fool for a doctor." Little did he know that his current doctor was on day one of his new career as an attending physician.



I first went down the cardiac pathway, ordering an ECG, chest xray and cardiac biomarkers. I gave him some nitro and morphine for his pain and it seemed to subside for a spell. His ECG had non-specific changes and his enzymes were normal. I had just finished reviewing his chest xray, when the nurse grabbed me and said his pain had returned along with his diaphoresis. I asked them to run another ECG while I discharged two other patients. His repeat ECG was unchanged so I went to see him. I was again astounded by his profound diaphoresis. I began to wonder, what am I missing and then it occurred to me: what diagnosis can I not afford to miss? Aortic Dissection.

I gave him some more morphine and ordered the CT. And wouldn't you know it, he did indeed have a Type B Aortic Dissection. But the story doesn't quite end there. After returning from CT, his pain had returned and he began to describe numbness in his left leg. I checked his lower extremity pulses and I was not able to palpate any pulses below the level of his left femoral artery. This was concerning to say the least. I consulted cardiothoracic surgery who said they were not equipped to manage a Type B Aortic Dissection with evidence of lower extremity vascular compromise and they suggested I transfer the patient to Mass General Hospital. Numerous calls later, a radial arterial line in place and a helicopter waiting, the patient was whisked off to MGH and is reportedly doing well.

Since that day my shifts have been getting progressively easier to manage. There are still times when I suppress the urge to run screaming from the department, but I continually count my blessings for having had the opportunity to train under such a wonderful staff at Maine Medical Center. I am pleased to report that I have found a new family at Portsmouth Regional and although I will always look back at my time at MMC with fondness, I am excited about the future. I am also pleased to report a new addition to my family. My son, Aidan Jack Carter was born July 26th at Portsmouth Regional and he and my wife are doing well. However, I do not recommend starting a new job, moving to a new location and having a child all in one month if it can be avoided. But whatever doesn't kill you, only makes you stronger, right? To quote the immortal words of Kermit the Frog: "It's not easy being green."

Report of Final Actions

Taken by the Maine EMS Investigations Committee

This notice is written in accordance with direction of the Maine EMS Board that the names, violations, and final disciplinary actions involving licensees who were subject to a fine, suspension, reprimand, requested voluntary surrender, and or revocation of their EMS licenses and or I/C certification be published in the Maine EMS Journal as a public notice.

The information listed in this section reflects the final action(s) taken by the Maine EMS Board. This information does not include pending actions or cases under appeal. This information does not contain, nor does it reflect, all of the factors involved in determining the final action, such as the severity of the misconduct/violation, the licensee's criminal and disciplinary history, or other mitigating factors. This publication is not intended as a guide to the level of disciplinary actions for a particular violation or misconduct, but rather as a publication that will increase awareness, reduce repetitive investigations, identify potential problem areas, and assist in determining areas for improvements in the quality and delivery of EMS statewide.

2007

Name: Lewis Anderson (EMS # 15450)
Violation: Practicing EMS patient care without a valid EMS license; Maine EMS Rules Chapter 11§(1)(3) and (1)(30).
Action: Mr. Anderson entered into a consent agreement, which imposed a fine of $300.00 and a Reprimand.

Name: Doug Patey (I/C # 164)
Violation: Providing instruction at a level for which a person is not certified to provide; Maine EMS Rules Chapter 9§(5)(B) and (5)(O).
Action: Mr. Patey entered into a consent agreement, which imposed a fine of $100.00 and a suspension.

Name: Timothy Larrabee (I/C # 524)
Violation: Providing instruction at a level for which a person is not certified to provide; Maine EMS Rules Chapter 9§(5)(B) and (5)(O).
Action: Mr. Larrabee entered into a consent agreement, which imposed a fine of $50.00 and a suspension.

Name: Scott Newton (EMS # 23208)
Violation: Violation of Consent Agreement; Maine EMS Rules Chapter 11§(1)(2).
Action: Mr. Newton entered into an amended consent agreement, for a conditional license and to provide quarterly reports from his counselor to MEMS.

Name: Darren Volkay (EMS # 19773)
Violation: Practicing EMS patient care without a valid EMS license; Maine EMS Rules Chapter 11§(1)(3) and (1)(30).
Action: Mr. Volkay entered into a consent agreement which imposed a Reprimand.

Name: Andy Cookson (EMS # 18948)
Violation: Criminal convictions for Criminal Mischief and Disorderly Conduct; Maine EMS Rules Chapter 11§(1)(13), (1)(14) and 32 M.R.S.A. §90(A)(5)(F)(H).
Action: Mr. Cookson entered into a consent agreement which required an evaluation from a counselor and a conditional license.

Name: Michael Murphy (EMS # 16305)
Violation: Practicing EMS patient care without a valid EMS license; Maine EMS Rules Chapter 11§(1)(3) and (1)(30).
Action: Mr. Murphy entered into a consent agreement which imposed a fine of $300.00.

Name: Joshua Pobrisio (EMS # 22287)
Violation: Practicing EMS patient care without a valid EMS license; Maine EMS Rules Chapter 11§(1)(30).
Action: Mr. Pobrisio entered into a consent agreement which imposed a fine of $300.00, all suspended and a suspension.

Name: Ricky Cray (EMS # 21712)
Violation: Criminal convictions for OUI and Theft; Maine EMS Rules Chapter 11§(1)(4), and 32 M.R.S.A. §90(A)(5)(G).
Action: Denial of renewal application.

2008

Name: Mark Stults (EMS # 18249)
Violation: Criminal conviction for Falsifying Physical Evidence; Maine EMS Rules Chapter 11§1(4), (1)(5), and (1)(14).
Action: Mr. Stults entered into a consent agreement for a conditional license

Name: Zachary Winship (EMS # 17142)
Violation: Criminal conviction for Child Pornography; Maine EMS Rules Chapter 11§1(4), (1)(5), and (1)(14).
Action: Requested voluntary surrender of his EMS license.

Name: Matthew Barnes (EMS # 18820)
Violation: Practicing EMS patient care without a valid EMS license; Maine EMS Rules Chapter 11§(1)(30) and 32 M.R.S.A. §82(1)
Action: Mr. Barnes entered into a consent agreement which imposed a Reprimand.

Lights, Camera...EMS!

By Daniel Limmer, EMT-P

Coming soon to a textbook near you: Maine EMS providers. During the month of August, dozens of Maine EMS providers served as models for an Emergency Medical Responder (the new name for First Responder) textbook to be released in 2009.

Providers from a variety of agencies from Rangeley to Waterville will see their photos in the book—but this isn't the only benefit of the shoot. Those involved in the shoot got a behind the scenes look at how textbooks are put together—and the sometimes painstaking detail taken to be sure the shot is just right.

Locations, chosen to add a sense of reality and variety to the book, included everything from outdoor scenes to homes to alleys. Regardless of the location, the models worked long hours with a sense of dedication, pride and professionalism. The talent and organizational skills of on-scene coordinator Kelly "Radar" Roderick (KVEMS) kept the shoot flowing smoothly.

In addition to the experience of being involved in a textbook photo shoot, models who volunteered their time have the added benefit of knowing that their efforts also help a greater cause—the Maine EMS Memorial. In return for the time and efforts of each of the dedicated providers, a donation will be made to the Maine EMS Memorial Fund.

Kelly Roderick receives EMSC Award

On June 26, 2008 at the annual EMSC (Emergency Medical Services for Children) grantee meeting held in Bethesda, Maryland Kelly Roderick was honored and presented with a service recognition award.

As many of you know, Kelly is the dedicated office manager for Kennebec Valley EMS. What some may not know is that for the past six years Kelly has been the Chair of the EMS-Children Injury Prevention Committee and served as the State's family representative for the EMSC Committee at the National EMSC meeting.

Kelly has logged countless hours in many EMSC-related projects. She is an instructor for the inhalant abuse program, the PEPP course coordinator, and was instrumental in the development of the playground safety education and training several years ago with schools and teachers across the state.

Congratulations Kelly for this much deserved recognition!

Presenting Kelly Roderick (center) with a service recognition award are, left, Dan Kavanaugh, federal EMSC Director and Theresa Morrison-Quinata, federal EMSC Outreach Coordinator.

MAINE EMS TEAM LEADERS

Ever wondered who to call when you have a question, complaint, concern or compliment about your EMS system? Listed below are the members of the Maine EMS Board, Maine EMS Staff, and the Regional Coordinators and Medical Directors. Each and every EMS team member in Maine is encouraged to get involved with how your system is run. So get involved—give us a call!

Maine EMS Board Members

Southern Maine EMS Rep	Ron Jones, EMT-P	23 Sterling Drive, Westbrook, ME 04092	TEL: 854-0654
Kennebec Valley EMS Rep	Tim Beals, EMT-P	PO Box 747, Waterville, ME 04903	TEL: 872-4000
Aroostook EMS Rep	James McKenney, EMT-P	229 State Street, Presque Isle, ME 04769	TEL: 768-4388
Tri-County EMS Rep	Lori Metayer, RN, EMT-P	3 Woodland Avenue, Lisbon Falls, ME 04252	TEL: 353-4546
Northeastern EMS Rep	Paul Knowlton, EMT-P	274 Pearl Street, Bangor, ME 04401	TEL: 941-5100
Mid-Coast EMS Rep	Steven E. Leach, EMT-P	PO Box 894, Union, ME 04862	TEL: 785-2260
Physician Rep	Peter DiPietrantonio, DO	4 Picnic Hill Road, Freeport, ME 04032	TEL: 373-2220
Nurse Rep	Geneva Sides, RN	PO Box 287, St. Albans, ME 04971	TEL: 487-5141 x269
First Responder Service	Richard Doughty, EMT-P	4153 Union Street, Levant, ME 04456	TEL: 941-5900
Emergency Medical Dispatch	James E. Ryan, Jr.	62 Main Trail, Hampden, ME 04444	TEL: 570-3773
For Profit Service	VACANT		
Not For Profit Service	Bob Hand, EMT-P	100 Hill Street, So. Paris, ME 04281	TEL: 890-6350
State Medical Control Director	Steven E. Diaz, MD	Maine EMS, 152 State House Station, Augusta, ME 04333	
Hospital Rep	Judy Gerrish, RN	891 West Main Street, Suite 400, Dover-Foxcroft, ME 04426	
Municipal EMS Service Rep	Wayne Werts, EMT-P, Chief	Auburn Fire Department, 550 Minot Avenue, Auburn, ME 04210	TEL: 783-6931
Fire Chief Rep	Roy Woods, Chief	Caribou Fire Department	
Public Rep	VACANT		
Public Rep	Ken Albert, Esq., RN	12 South Ridge Lane, Lewiston, ME	TEL: 777-5200

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REGION 4 — Rick Petrie, EMT-P, Northeastern Maine EMS — Dr. Jonnathan Busko, Medical Director
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REGION 5 — Steve Corbin, Aroostook Maine EMS — Dr. Jay Reynolds, Medical Director
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